BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

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| In the Matter of:<br><br>AMAYA L.,<br>Claimant,<br>and<br><br>WESTSIDE REGIONAL CENTER,<br>Service Agency. | OAH No. L 2006090493 |

DECISION

This matter came on for regularly scheduled hearing on November 1, 2006, at Culver City, California, before David B. Rosenman, Administrative Law Judge, Office of Administrative Hearings, State of California. The Westside Regional Center (Service Agency) was represented by Lisa Basiri, Fair Hearing Coordinator, and Martha Thompson, Fair Hearing Coordinator. Claimant Amaya L. was represented by her mother, Eve L.[1]

Evidence was received by documents and testimony. The record was closed and the matter was submitted for decision on November 1, 2006.

ISSUES

The parties agreed that the following issues are to be resolved:

1. Should the Service Agency increase the hourly rate for specialized supervision and in-house respite from $15 per hour to $20 per hour, gross?

2. Does Claimant qualify for in-home nursing respite and, if so, should in-home nursing respite increase from 28 hours per month to 48 hours per month, effective July 6, 2006?

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[1] Claimant and her mother are referred to in this way to protect their confidentiality.

## FACTUAL FINDINGS

The Administrative Law Judge finds the following facts:

*Jurisdiction*

1. Claimant was born August 2, 2002, and is four years old. Claimant is eligible for services from the Service Agency based on diagnoses of autism and seizure disorder. The services provided include in-home respite and program respite for the family, after school care, extended school year services, and a behavior intervention program.

2. On July 6, 2006, Claimant's mother requested an increase in the hourly amount for in-home respite care and supplied supporting information. (Exhibit C-2.) In a letter and notice of Proposed Action dated August 9, 2006, the Service Agency denied the request. (Exhibits C-4 and SA-1.)

3. Claimant's mother submitted a request for Fair Hearing dated August 28, 2006 (Exhibits C-5 and SA-1), and this hearing ensued.

*Background*

4. Apparently, there was a prior dispute between the parties, including some of the services that are now at issue, that was settled in March 2006.[2] In June 2006, Claimant's mother sent to the Service Agency several resumes she received in response to her Internet posting requesting childcare for Claimant. (Exhibit C-1.) Of the seven resumes, five include pay rates: one for $40 per hour, one for $25 per hour, and three for $20 per hour.

5. (A) Although there was some confusion in the evidence over whether the request was made earlier, in a letter dated July 6, 2006, Claimant's mother requested an increase of the rate for specialized supervision and in-home respite from $15 per hour to $20 per hour, gross. The letter also requested to increase in-home respite to 48 hours per month (from a present level of 21 hours per month). Some of the reasons given for the requested increase were Claimant's behavioral issues and her complex medical needs.

(B) More specifically, the letter contends that Claimant qualifies as a medically fragile child under the Service Agency's guidelines for nursing respite due to: risk of respiratory arrest due to asthma; seizure disorder not controlled by medication; use of a nebulizer to assist in breathing; and need for nursing care for use of an epi-pen injection due to peanut allergy, her

[2] A reference to the settlement is found in Exhibit C-2, Claimant's mother's letter to the Service Agency dated July 6, 2006. This letter also refers to prior letters dated May 22 and June 1, 2006. The settlement agreement and the letters were not placed in evidence.

neurological condition of organic encophilopathy of the brain, her severe allergies to food and environmental factors, and her moderate hearing loss.

6. In response, the Service Agency sent a Notice of Proposed Action, dated August 9, 2006 (Exhibit SA-1), denying the increase in hourly rate and agreeing to increase respite to 28 hours per month. It stated that the hourly rate had been agreed to in a previous matter, and that the number of hours "reflects the level of support appropriate to [Claimant's] needs."

7. (A) In the hearing, Claimant's mother testified to the complexity of Claimant's condition. Claimant was born with a heart abnormality that requires her heart rate to monitored so that it can be reported if it gets too high. Some of Claimant's medications and her asthma may increase her heart rate, so knowledge of these issues is vital for any caregiver. Similarly, when Claimant has a seizure or some of her allergic reactions, she is less able to communicate her situation and needs. Again, a caregiver would have to be familiar with the causes and frequency of onset and the effects on Claimant. Due to Claimant's hearing loss, her communication is idiosyncratic, another issue requiring caregiver awareness.

(B) Claimant's medications are prescribed, and several require assistance in administration. For example, because Claimant cannot easily swallow her seizure medications, given three times per day, her mother crushes them into her juice. Her nebulizer treatments require placing liquid medication into an apparatus attached to a face mask. The epi-pen is a pre-measured injection that must be administered by an adult in situations where Claimant is in distress due to allergic reaction. When used, it is recommended that Claimant be taken immediately to an emergency room for further treatment or monitoring.

8. The medical concerns noted above are confirmed by reports prepared by Michael Sachs, M.D.; Robert Eitches, M.D., an allergist and immunologist; Ronald Gabriel, M.D., a pediatric neurologist; and Friedel Cunningham, a specialist in clinical audiology. (Exhibit C-3.)

9. Claimant's mother has not been able to obtain help with childcare from friends or family who are willing to undertake the responsibility for managing Claimant's behavior and administering her medications.

10. (A) Bill Freeman is a registered nurse who is a benefits specialist for the Service Agency. Mr. Freeman gave extensive testimony about the Service Agency's process of determining the level of care that can be authorized for a consumer with medical needs, and locating appropriate caregivers.

(B) Generally, if a consumer's medical needs do not require a licensed nurse to perform the functions, the focus is on finding a family member or friend who can be trained, or using an intermediate care company experienced in caring for sick people. If licensed nursing is needed, an outside nursing agency can be engaged, by use of a Treatment Authorization Request, to assess the need for nursing care. Medi-Cal can find a generic resource to provide

such care through use of a process called Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Such a care plan first requires a nursing assessment and plan, which costs $105 for observation and preparation and must be updated every six months. However, before this level of care is given, there are several lower levels of care that are more economical and should be considered.

(C) In Mr. Freeman's opinion, the level of care required by Claimant can be provided by a worker under the In-Home Support Services (IHSS) program provided by the county. This program is a generic resource available if the consumer is Medi-Cal eligible. The IHSS rate is $8.45 per hour.

(D) Some vendors for regular respite services can provide workers to handle such tasks, at a cost of about $13 per hour to the vendor, with take-home pay to the caregiver of about $9 per hour.

(E) The next step up is agency respite, which is not up to the level of care of a licensed vocational nurse (LVN) or registered nurse (RN), at a cost of about $16 per hour to the agency, with take-home pay to the caregiver of about $11 to $13 per hour.

(F) Next would be a Certified Home Health Aide. At this level of care and higher, an EPSDT would be required. The Medi-Cal rate is $18.90 per hour to the agency, with take-home pay to the caregiver of about $10 to $12 per hour. There is much overhead to the agency due to requirements for supervision and due to increased liability issues.

(G) Next would be an LVN through an agency, at a cost of $29.41 per hour to the Service Agency. This level of care is necessary, usually, when there is a G-tube for administration of nutrition and medication.

(H) For RN care, the Service Agency uses a rate of $40.57 per hour, as required by Medi-Cal.

11. (A) Mr. Freeman has reviewed the documents concerning the level of care required for Claimant. In his opinion, he would not recommend that the Service Agency issue a treatment request to Medicare because Claimant's needs do not meet the threshold for nursing care to be approved. For example, although the epi-pen punctures the skin, it is often used by non-licensed adults to administer when the child is in need, such as at school, where a teacher or aide is closer than the nurse and can give the medication. Similarly, Claimant's nebulizer breathing treatments can be administered by anyone trained to prepare the medications and monitor Claimant while she breathes them through a mask.

(B) Mr. Freeman agrees that, due to licensing requirements and liability issues, the minimum level of licensed professional care necessary to attend to Claimant's medical needs would be at the level of an LVN. However, in his experience, such needs can be

commonly met by unlicensed individuals who have been properly trained, at a substantially reduced pay rate. Further, in his experience, agencies providing nursing level care often have personnel changes due to the shortage of nurses and other factors, resulting in inconsistent and changing staffing. The particular nuances of a consumer can be handled more consistently by a non-licensed person who is properly trained and has the time to gain experience with the child. Mr. Freeman is familiar with agencies that have successfully located caregivers under similar circumstances as presented here. The Service Agency pays one such agency about $13 per hour, and another about $16.60 per hour.

(C) Mr. Freeman is aware of the rate being paid for Claimant's care of $15 per hour. This is an exception to the usual rates for respite and childcare. He is aware of a few other situations where Service Agency consumers have been approved for this exception.

12. The most recent Individual Program Plan for Claimant adds the following relevant information. Claimant and her mother are a one-parent family. In addition to the disputed amount of respite via parent voucher, the Service Agency funds 14 hours per month of program respite. Claimant's allergies and seizures are key medial issues. Medical care is funded by Medi-Cal. Claimant receives special education services from the Los Angeles Unified School District and attends the Julia Ann Singer Therapeutic School. Claimant has difficulties with transitions and changes and is prone to tantrum when she is frustrated. She is slow to interact with other children and becomes overwhelmed in large groups and can become physically aggressive or totally withdraw and be unresponsive. The Service Agency provides 73.5 hours per month of after-school care via parent voucher and a behavior intervention plan via Beautiful Minds. It also provides extended school year services.

13. The Service Agency has written guidelines for the services at issue. In summary, the respite guidelines state as the goal that the Service Agency will give preference to those services best designed to achieve the desired outcome. (Exhibit SA-3.) To determine the appropriate level (number of hours) of respite for a minor such as Claimant, the guidelines state that each family has different needs, but provide several different levels. The first, of up to seven hours per month, provides time off for parents to attend training or other activities. The next level, up to 14 hours per month, is justified when "specialized intensive care" is required, such as for toileting and feeding, or when support systems are lacking, such as a one-parent family. Up to 21 hours per month are provided when other difficult conditions exist, such as behavior challenges. Increases beyond this level are provided "upon documentation of need," such as a requirement for 24-hour care, multiple consumers in the family, or emergency situations.

14. The Service Agency has written guidelines for day care services. (Exhibit SA-3.) These stress cost effectiveness and provide that the Service Agency will pay any cost that exceeds the price of after-school care for a child without disabilities.

15. (A) The Service Agency has written guidelines for in-home nursing respite services. (Exhibit C-6.) Such services are available for consumers who are medically fragile or

technology dependent. Among other things, these guidelines provide that such services will be provided only after other funding resources have been exhausted, such as Medi-Cal and IHSS. If so, and prior to establishing the level and type of care to be provided, a comprehensive nursing assessment by an RN would be obtained. Then, if warranted, nursing respite hours would be considered in a range from 16 to 48 hours per month.

(B) Such services are available for consumers meeting one or more of the following conditions, as they relate to Claimant: risk of respiratory arrest; uncontrolled seizure disorder; use of special equipment such as oxygen or respirator; or requirements for other types of basic and/or specific nursing care.

(C) The type of professional most appropriate to provide the care is dependent on the specific needs of the individual. The guidelines discuss, generally, the capabilities and limitations of RN's, LVN's and licensed practical nurses, and home health aides.

## CONCLUSIONS OF LAW AND DISCUSSION

Pursuant to the foregoing factual findings, the Administrative Law Judge makes the following conclusions of law and determination of issues:

1. Throughout the applicable statutes and regulations (Welfare & Institutions Code sections 4700 - 4716, and California Code of Regulations, title 17, sections 50900 - 50964)[3], the state level fair hearing is referred to as an appeal of the regional center's decision. Particularly in this instance, where Claimant seeks to obtain higher levels of services than are presently being provided, Claimant has the burden of proof to establish that she is entitled to the levels of services she seeks.

2. In order to determine how an individual consumer is to be served, regional centers are directed to conduct a planning process that results in an Individual Program Plan (IPP) designed to promote as normal a life as possible. (Code § 4646; *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384, 389.) Among other things, the IPP must set forth goals and objectives for the client, contain provisions for the acquisition of services (which must be provided based upon the client's developmental needs), contain a statement of time-limited objectives for improving the client's situation, and reflect the client's particular desires and preferences. (Code §§ 4646; 4646.5, subds. (a)(1), (a)(2) and (a)( 4); 4512, subd. (b); and 4648, subd. (a)(6)(E).)

The services to be provided to any consumer must be individually suited to meet the unique needs of the individual client in question and, within the bounds of the law, each consumer's particular needs must be met. (See, e.g., Code §§ 4500.5, subd. (d), 4501, 4502,

[3] All statutory references are to the Welfare and Institutions Code, except where indicated.

4502.1, 4512, subd. (b), 4640.7, subd. (a), 4646, subd. (a), 4646, subd. (b), 4648, subd. (a)(1) & (a)(2).) The Lanterman Act assigns a priority to services that will maximize the consumer's participation in the community. (Code §§ 4646.5, subd. (2); 4648, subd. (a)(1) & (a)(2).)

3. Section 4512, subdivision (b), of the Lanterman Act states in part:

"'Services and supports for person with developmental disabilities' means specialized service and supports or special adaptations of generic services and support directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives. . . . The determination of which services and supports are necessary shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of . . . the consumer's family, and shall include consideration of . . . the effectiveness of each option of meeting the goals stated in the individual program plan, and the cost-effectiveness of each option. Services and supports listed in the individual program plan may include, but are not limited to, diagnosis, evaluation, treatment, personal care, day care, . . . respite . . . ."

4. Services provided must be cost effective (Code § 4512, subd. (b)), and the Lanterman Act requires the regional centers to control costs as far as possible and to otherwise conserve resources that must be shared by many consumers. (See, e.g., Code §§ 4640.7, subd. (b), 4651, subd. (a), 4659, and 4697.) A fair reading of the law is that a regional center is not required to meet a consumer's every possible need or desire, in part because it is obligated to meet the needs of many children and families.

One important mandate included within the statutory scheme is the flexibility necessary to meet unusual or unique circumstances, which is expressed in many different ways in the Lanterman Act. Regional centers are encouraged to employ innovative programs and techniques (Code § 4630, subd. (b)); to find innovative and economical ways to achieve the goals in an IPP (Code § 4651); and to utilize innovative service-delivery mechanisms (Code §§ 4685, subd. (c)(3), and 4791). Section 4690 requires the Department of Developmental Services to establish an equitable process to set rates for payment for such services in a manner that assures their high quality.

5. In the present case, Claimant has established that she has certain medical conditions and behavioral issues that require special attention to her needs and the condition of her health. Mr. Freeman's opinion that Claimant would not qualify for Medi-Cal nursing services is credible and uncontroverted. The evidence produced in this hearing was not sufficient to establish that Claimant qualifies as medically fragile under the Service Agency guidelines. See Factual Findings 5, 6, 7, 8, 10, 11 and 15.

6. Even if Claimant produced evidence that she qualifies, the guidelines themselves

require exhaustion of other resources before in-home nursing respite is provided. In this manner, the guidelines are consistent with the emphasis placed on cost-effective services throughout the Lanterman Act. Mr. Freeman's testimony about cost-effective options should be examined and, hopefully, implemented to determine if Claimant's needs can be met without resorting to a type of care that requires a higher level of trained personnel with a related increase in costs. See Factual Findings 10, 11, 13, 14 and 15.

7. Because Claimant did not establish that she is presently qualified for in-home nursing respite, the issue of whether in-home nursing hours should be increased is moot.

8. At this time, Claimant has not established that the Service Agency has improperly applied its policies or violated the applicable statutes. However, if Claimant and the Service Agency are unable to identify or engage a service provider that meets Claimant's needs at a level of service lower than that requiring professionally licensed caregivers, in the future Claimant may attempt to establish that she qualifies for such services.

## ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

The Claimant's appeal of the Service Agency's determination to deny an increase in hourly rates is denied. The Claimant's appeal of the Service Agency's determination that Claimant does not qualify for in-home nursing respite is denied.

DATED: December 14, 2006.

DAVID B. ROSENMAN
Administrative Law Judge
Office of Administrative Hearings

**Notice: This is the final administrative decision pursuant to Welfare and Institutions Code section 4712.5, subdivision (a). Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.**